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Acceptance and Commitment Therapist Views on the Sacred

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Abstract

Spirituality and/or religion (S/R) continue to be an important topic in mental health treatment, especially regarding their relationship to a psychotherapist's theoretical orientation and practice with clients. Given the increased relevance of spirituality to third-wave cognitive behavioral therapies, the current study explores the S/R of Acceptance and Commitment Therapy (ACT) psychotherapists and how their S/R is associated to their attitudes and behaviors within mental health and their use of ACT. Online surveys were administered, producing a sample of 97 ACT psychotherapists in the United States. Results indicated low levels of religiosity and high levels of spirituality among ACT psychotherapists in comparison to other mental health professionals. The personal S/R of ACT psychotherapists also seemed to influence their attitudes and behaviors regarding S/R within their practice. In addition, more preferred use of certain ACT processes was correlated with these S/R attitudes and behaviors. To explore the nature of these correlations, the scientific and spiritual roots of ACT are discussed.

Acceptance and Commitment Therapist Views on the Sacred

In studying humanity's quest for understanding and experiencing the divine, there has been varied consensus in how researchers have defined spirituality and/or religion (S/R). Religion appears to be a much easier construct to define than spirituality, as its very nature is characterized by an organized institution, a more outward and prescribed set of beliefs and values that is shared by a group of people. Spirituality, however, refers to a more inward, subjective, and individual experience that may or may not be shared with others (Hill & Pargament, 2003; Miller & Thoresen, 1999). In other words, as stated by Miller and Thoresen, "religion is characterized in many ways by its boundaries and spirituality by a difficulty in defining its boundaries" (p. 6). Despite the more relative and idiosyncratic nature of the term, spirituality, researchers have found somewhat specific and shared interpretations, such as in Miller's and Sheppard's (2014) qualitative study on the definitions provided by psychology graduate students. These shared themes described spirituality as a relational connection to self, the divine, others, and/or nature, individually defined, relative and unspecific, and the sense of something greater and more powerful than oneself. Not only does spirituality seem to be a relative and contextual aspect of experience, but also its very lack of specificity and elusiveness make the use of this word appropriate for many people.

Importance of S/R in Mental Health

In spite of their differences, both spirituality and religion can function usefully and effectively in mental health treatment. Research has indicated an inverse relationship between levels of spirituality and psychological and medical symptoms (Carmody, Reed, Kristeller, & Merriam, 2008). More specifically, psychological benefits can result from gaining perceived closeness and attachment to a higher power, using S/R as a motivating force and/or values to

guide one's behavior, receiving social support from a S/R-based community, and grappling with S/R-type struggles that bring existential concerns to light (Hill & Pargament, 2003). Hayes (1984) proposed that the verbal concept of spirituality may refer to a certain experiencing of one's perspective that would encourage immediate contingency-shaped behavior and, thus, lead to increased psychological flexibility.

Regardless of personal S/R, spirituality and religion continue to be prevalent and salient factors among the general public in the United States. Recent estimates suggest that 86% of Americans believe in God or a universal spirit, and 78% describe religion in their lives as very or fairly important (Gallup, 2015). Additionally, it is estimated that 87% consider themselves to be religious and/or spiritual, with 33% identifying as only spiritual (Gallup, 2003a), and that 69% of Americans desire spiritual growth in their everyday lives (Gallup, 2003b). However, when examining the S/R of mental health professionals, a different pattern emerges. While a majority of psychotherapists identify with a particular religious belief or affiliation that is similar to mainstream America, the level of outward religious practices and/or institutional involvement among mental health professionals is far lower than the American public (Bergin & Jenson, 1990; Delaney, Miller, & Bisono, 2013; Shafranske & Malony, 1990; Walker, Gorsuch, & Tan, 2004). On the other hand, spirituality among mental health professionals is similar to the general American public, with a majority identifying as spiritual (Allman, de la Rocha, Elkins, & Weathers, 1992; Rosmarin, Pirutinsky, Green, & McKay, 2013). A study by Delaney et al. (2013) found that around 80% of psychologists who are members of the American Psychological Association (APA) rated spirituality as being fairly to very important. Additionally, Smith and Orlinsky (2004) found that around 78% of psychotherapists report spiritual concerns, with 51% identifying with a sense of spirituality that is not religious. Thus, it seems that mental health

professionals embrace spirituality over religion compared to the general public and favor a more personal, private, and spiritual type of belief system.

Given the difference in S/R attitudes between mental health professionals and prospective mainstream clients, considerations of providing multiculturally competent treatment is important. Indeed, as Walker et al. (2004) stressed, S/R should be examined not only in terms of respect and comfort for clients' cultural backgrounds and values but also for providers to be self-aware of their own culture and helping style and how this influences their responses to clients in assessment and treatment. Like other cultural factors, research has shown that the S/R of mental health professionals influences their practice with clients and how they perceive and approach a client's S/R (Allman et al., 1992; Bilgrave & Deluty, 1998; Rosmarin et al., 2013; Shafranske & Malony, 1990). Additionally, research has shown that levels of training in S/R are correlated with psychotherapists' reports of clients that bring up S/R in treatment. This suggests that more training in S/R issues supports increased sensitivity to these issues when they do come up in therapy (Hofmann & Walach, 2011; Ragan, Malony, & Beit-Hallahmi, 1980; Shafranske & Cummings, 2013). In terms of the cultural differences in how religion and spirituality are considered, Shafranske and Cummings (2013) suggested that mental health professionals may prefer a more individualistic understanding and manifestation of spiritual connection. This attitude would perhaps signify a psychotherapist's Westernized approach to therapy that favors one's individual expressions and values over those of a group or system, as research has shown that psychologists are more dissimilar religiously to the general public when compared to Marriage and Family Therapists (Bergin & Jenson, 1990; Walker et al. 2004). Thus, recognizing our own perception of what spirituality and religion mean and the functions they serve are a part of culturally competent practice.

S/R and Theoretical Orientation

Since therapist S/R influences their conceptualizations and interactions with clients, it would stand to reason that their chosen theoretical approach would also be affected. Several studies have revealed associations between psychotherapist religious beliefs and their theoretical orientations. Among psychologists, Bilgrave's and Deluty's (1998) found that Orthodox Christianity was correlated with a cognitive-behavioral approach and Eastern and mystical beliefs with a more humanistic/existential approach. A later study by Bilgrave and Deluty (2002) confirmed that those with a more humanistic orientation held more Eastern and Mystical beliefs, while conservative Christian psychologists were again more likely to affiliate with a cognitive-behavioral approach. Bilgrave and Deluty suggested that, outside of its scientific underpinnings, the therapeutic techniques of CBT were more compatible with Christian beliefs and/or useful in providing Christian-based psychotherapy. However, Rosmarin et al. (2013) did not find broad support of this thesis in a survey of members of the Association for Behavioral and Cognitive Therapies (ABCT), in which mental health professionals who practiced CBT actually identified as much less religious, in affiliation and religious practice, than members of the APA, who were surveyed in 2003 in a separate study (Delaney et al. 2013). At the same time, a majority of the ABCT members identified as spiritual, with almost twice as many placing personal importance on spirituality as religion compared to members of the APA. It is therefore unclear if the differences between APA and ABCT members are due to a recent increase in spirituality that is separate from religion and/or to a pattern of S/R unique to CBT psychotherapists that conflicts with past studies.

Relevance of S/R to Third Wave CBT

While the relationship between S/R beliefs and CBT remains unclear, the relationship between S/R variables and the growing popularity of so-called *third wave* cognitive behavior therapies has yet to be investigated (Rosmarin et al., 2013). These third wave therapies—examples of which include ACT, Dialectical Behavior Therapy (DBT), Functional Analytic Psychotherapy (FAP), and Mindfulness-Based Cognitive Therapy (MBCT)—incorporate acceptance, mindfulness, values, and context that may be more relevant to S/R than traditional CBT (Hayes, 2004) and represent a move towards integrating science and spirituality within psychotherapy (Andersson & Asmundson, 2006; Seiden & Lam, 2010). Parallels with certain Eastern mystic traditions (e.g., Zen Buddhism) have also been noted (see e.g., Hayes, 2002; Kang & Whittingham, 2010). These third wave therapies tend to utilize interventions similar to humanistic/existential and family systems approaches, given their emphasis on client values and context of behavior (Brown, Gaudiano, & Miller, 2011). Furthermore, acceptance-based approaches (e.g., mindfulness) have been shown to improve spiritual well-being (Carmody et al., 2008). Many have even argued that the theories and techniques behind these newer treatment models correspond to Christian doctrine and traditions (Behrens & Terrill, 2011; Hathaway & Tan, 2009; Karekla & Constantinou, 2010; Knabb, Ashby, & Ziebell, 2010; Knabb & Grigorian-Routon, 2013; Tan, 2011; Vandenberghe & Prado, 2009), as well as Islam (Mirdal, 2012) and Judaism (Behrens & Terrill, 2011; Shimoff, 1986).

The Science and Theory of ACT

Among third-wave cognitive behavioral therapies, ACT is arguably at the forefront of integrating, or at least valuing, both science and spirituality. Not only has ACT been subject to

extensive clinical trials, it is also thoroughly grounded in basic science research programs (viz., operant conditioning, relational frame theory) from which it was developed. At the same time, spiritual concerns and issues have long been associated with ACT's development (e.g., Hayes, 2004), and one among its six core clinical processes, namely self-as-context, has been described in terms related to spirituality and transcendence (Hayes, 1984). As ACT is the focus of the present study, clarification of its core clinical processes requires a brief review of the science and theory behind the therapy.

ACT is built upon the philosophies of process thinking, pragmatism, functionalism, and contextualism, as well as the science of Behavior Analysis and Relational Frame Theory (RFT; Chiesa, 1994; Hayes, Barnes-Holmes, & Roche, 2001; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The aims of functional contextualism are not to explain behavior in terms of cause and effect, but to examine behavior through functional relations that highlight the interdependence between behavioral and environmental events. Human experience is also viewed as a continuous process of these interactions between behavior and the environment, rather than fixed events or structures. In addition, rather than trying to determine what is true, functional contextualists focus on what is shown to be effective and useful. ACT uses the methods of Behavior Analysis, the purpose of which is to predict and influence human behavior. When applying Behavior Analysis to the unique and remarkable human ability of language, RFT is used to describe how humans verbally relate events, allowing us to derive the functions of one stimulus to another through language or concepts. Although useful in many contexts, verbal relational framing is thought to be behind much of human suffering given that they tend to respond to conceptual stimuli over directly-acting stimuli in the present moment, and that clients may view their private responses to stimuli (e.g. thoughts and feelings) as a problem that needs

to be fixed (Hayes, 2004). Thus, the goal of ACT, which is to increase psychological flexibility, involves "the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). This is established through six core processes, including Acceptance, Cognitive Defusion, Present Moment, Self-as-Context, Values, and Committed Action.

Acceptance is an alternative to experiential avoidance, especially when avoidance constricts one's freedom to act. Thus, acceptance involves the active embrace of internal, private events without unnecessary attempts to change their frequency or form (Hayes et al., 2006). Cognitive Defusion attempts to change the function of these private events so that, rather than remaining attached to and believing in the substance and content of internal experiences, clients can reduce their literal quality and see them for what they are. Making contact with the Present Moment consists of experiencing psychological and environmental events as they occur without making judgments, creating a more mindful and direct experience of the world that leads to more control over one's behavior. Being fully aware of the present moment leads to a nonverbal mode of awareness where the self is a locus of perspective. Rather than clinging to a conceptualized and rigid sense of self, Self-as-Context aims for clients to consider perspectives of the self that are flexible and intentional in how they relate to their experience. Additionally, Values are qualities of purposive action, chosen by the client, that demonstrate how one's life matters in a particular moment and leads to more intentional, meaningful action rather than behavior driven by avoidance. Finally, Commitment takes place when clients achieve concrete goals that are aligned with their values in order to develop an increasing pattern of effective, significant action. All six of the ACT processes are overlapping and interrelated, each of them taking place in no particular order throughout the course of therapy.

Present Study

Given the increased relevance of research on ACT and S/R, we might expect to find a unique pattern of S/R beliefs and attitudes among ACT psychotherapists that differs from other mental health professionals. In addition, it would be interesting and useful to examine how a therapist's practice of ACT is affected by personal and professional S/R beliefs and attitudes. Indeed, ACT psychotherapists are encouraged to utilize and experience these processes for themselves to facilitate effective therapy, as "the therapist and client are thought to be swimming in the same stream" (Hayes, 2004, p. 660). However, to date, no one has surveyed the S/R of these therapists separate from those who might practice traditional CBT or identify as using a cognitive and/or behavioral approach to psychotherapy. The aims of the present study include gaining a general appraisal of S/R beliefs and attitudes of ACT psychotherapists, both personal and pertaining to mental health, as well as exploring how these beliefs and attitudes might be connected to how ACT processes are utilized in treatment.

Method

Participants

Participants included psychotherapists who practice ACT with clients in the United States. They were recruited through the Association for Contextual Behavioral Science (ACBS) Facebook pages and ACT for Professionals list serve. Participants completed a brief (5 to 10 minute) 23-item survey. The survey was administered online in 2014, measuring demographics (gender, age, ethnicity, education, years of therapy experience, and status of ACBS membership), personal S/R, attitudes regarding S/R within mental health, and use of ACT and specific ACT processes in psychotherapy.

In total, 123 surveys were received. However, due to technical issues with the survey's website, as well as other unknown factors, 25 surveys were not completed, resulting in 97 completed surveys. Surveys were considered complete if they included four or less omitted items. Ages of participants ranged from 23 to 69, with a median age of 44 and a mean age of 45 (*SD* = 14.0). Table 1 summarizes the demographic data from the completed surveys. Participants identifying as Caucasian/White constituted 91% of the sample and the sample was made up of slightly more females than males.

Table 1

Demographics

	n	%
Gender		
Male	42	43
Female	53	55
Other	2	2
Ethnicity		
White/Caucasian	88	91
Hispanic/Latino	2	2
Black/African American	1	1
Asian/Pacific Islander	3	3
Other	3	3
Degree		
Bachelor's	5	5
Master's	49	51
Doctorate	43	44
ACBS Membership		
Professional	71	73
Student	22	23
None	4	4

Note. Percentages are rounded to the nearest whole number. ACBS = Association for Contextual Behavioral Science.

Measures

Personal S/R was assessed using six items adapted from past studies measuring S/R of mental health professionals (Bergin & Jenson, 1990; Delaney et al., 2013; Rosmarin et al., 2013). The six items queried participants on their religious belief system, how often they attended religious services, how often they performed private rituals and/or traditions, the personal importance of religion and spirituality in their lives, and how effective they were in living out their belief systems.

An additional six items were used to assess attitudes and behaviors regarding S/R and mental health. In order to provide more accurate comparisons of ACT psychotherapists to other mental health professionals, the items were adapted from past studies, specifically those which had surveyed CBT psychotherapists (Rosmarin et al., 2013) and APA psychologists (Delaney et al., 2013). These items included attitudes about the relevance of S/R to mental health and to personal professional practice, the frequency in which participants brought up S/R in their clinical work, and how competent and comfortable they felt in addressing these issues with clients.

The final portion of the survey examined the learning and use of ACT, including how participants learned about ACT, their personal sense of competence in using ACT, and how much they valued and utilized core ACT processes. Items addressing core ACT processes were divided into three pairings (see Hayes 2004): Acceptance and Defusion, Present Moment and Self-as-Context, and Values and Commitment.

Analysis

Non-demographic survey items were based on a 5-point Likert scale. Items assessing frequency were scored 1 to 5 with the following categories: "Never," "Rarely," "Sometimes," "Often," and "Always." All other items were also scored 1 to 5, including "Not at all," "Slightly," "Somewhat," "Mostly," and "Very much," respectively. Missing data from surveys with fewer than five omitted items were substituted using the average scores of all other responses on a particular item. In some instances, data were also analyzed by collapsing them into broader categories, such as "Never/Rarely", "Sometimes," and "Often/Always."

First, descriptive statistics were used to measure the frequency of responses for personal S/R, attitudes and behaviors regarding S/R within mental health, and the use of various ACT processes. Certain survey item responses were compared to response rates from past studies, including those that surveyed APA psychologists (Delaney et al., 2013), CBT practitioners (Rosmarin et al., 2013), and the American public (Gallup, 2003, 2015). It should be noted, however, that a number of this study's survey items differed slightly from past studies, making comparisons between studies difficult. In addition, there were slightly more female (55%) than male (43%) respondents relative to these comparative studies (CBT, 28% female, 72% male; APA, 42% female, 58% male), and the mean age of the present sample (viz., 44.7) fell between the CBT (M = 38) and APA (M = 56.7) samples. Survey respondents were nearly identical with CBT (89%) and APA (93%) samples in terms of racial identification.

Data were primarily analyzed using nonparametric statistics, given the mostly nominal nature of survey items. Spearman's rho (r_s), a rank-order correlation coefficient, was used to calculate the direction and strength of the relationship between pairs of frankly categorical

variables. In some instances, the Freidman rank test was used to explore, post hoc, any significant differences between categorical variables and those more interval in nature.

Results

Religious and Spiritual Characteristics of ACT Therapists

The religious and spiritual characteristics of ACT psychotherapists are summarized in Table 2. Among the interesting findings, ACT psychotherapists were much less religious compared to survey results of other mental health clinicians and the general public. In all, nearly half (46%) of the ACT respondents identified as atheist, agnostic, or nonreligious compared to 30% of the CBT practitioners (Delaney et al., 2013), 16% of APA psychologists (Rosmarin et al., 2013), and 20% of the American public (Gallup, 2003, 2015). Compared to CBT practitioners (51%), APA psychologists (48%), and the general public (22%), ACT psychotherapists were also less concerned about religion in their personal lives with two-thirds (66%) of respondents rating religion as being "slightly" (otherwise worded "not very") or "not at all" important.

However, in support of a distinction between spirituality and religion, nearly the same percentage of ACT respondents (63%) rated spirituality as being more than "somewhat" important in their lives compared to only 20% who felt that way about religion. Given the mindfulness component of ACT, it is perhaps not surprising that spirituality would be held in higher importance by ACT psychotherapists who also were more than twice as likely to identify with a Buddhist or Eastern belief system (18%) than CBT practitioners (8%). In terms of belief system, ACT psychotherapists were also much less likely to affiliate with Christianity and/or Catholicism (22%), relative to the percentages in the aforementioned surveys (see Delaney et al.,

2013; Gallup, 2003, 2015; Rosmarin et al., 2013) and more closely resembled the general public in Jewish affiliation (2% vs. 5%) compared to CBT practitioners (22%) or APA psychologists (23%).

In contrast to CBT practitioners and APA psychologists, ACT respondents were also more likely to "never" or "rarely" attend religious services (ACT: 72%; CBT, 64%; and APA, 55%). However, only 33% of ACT respondents reported that they "never" or "rarely" engaged in private rituals such as prayer or meditation, with 35% reporting that they use private rituals more than "sometimes." The surveys of CBT practitioners and APA psychologists, on the other hand, queried how often their respondents engaged in prayer only, making these behaviors difficult to compare. In general, the discrepancies between religious attendance and private rituals, as well as importance of religion and importance of spirituality, support previous research in demonstrating a more personal and spiritual style of relating to the sacred for mental health professionals versus a religious and institutionalized style (Allman et al., 1992; Delaney et al., 2013; Rosmarin et al., 2013; Smith & Orlinksy, 2004). In comparison to other mental health professionals, this type of spirituality may also be particularly true of ACT psychotherapists.

Finally, it is worth noting that, consistent with ACT values, over 70% of ACT respondents felt that they were either "mostly" or "very much" effective in living their lives according to the S/R beliefs. Unfortunately, this statistic was not available from other survey samples for comparison.

Table 2

Spirituality and Religion of ACT Psychotherapists

Item	*n*	%
Which belief system do you most identify with?		
Christian/Catholic	21	21.6
Jewish	5	5.2
Buddhist/Eastern	17	17.5
Atheist/None	25	25.8
Agnostic	20	20.6
Other	9	9.3
How often do you attend religious services?		
Never	37	38.1
Rarely	33	34.0
Sometimes	11	11.3
Often	7	7.2
Always	9	9.3
How often do you pray, meditate, and/or perform other private S/R rituals?		
Never	15	15.5
Rarely	17	17.5
Sometimes	31	32.0
Often	23	23.7
Always	11	11.3
How important is religion in your life?		
Not at All	47	48.5
Slightly	17	17.5
Somewhat	14	14.4
Mostly	6	6.2
Very Much	13	13.4
How important is spirituality in your life?		
Not at All	7	7.2
Slightly	15	15.5
Somewhat	14	14.4
Mostly	18	18.6
Very Much	43	44.3
How effective are you in living your life according to this S/R belief system?		
Not at All	2	2.1
Slightly	6	6.2
Somewhat	20	20.6
Mostly	49	50.5
Very Much	20	20.6

Note. Percentages are rounded to the nearest tenth. ACT = Acceptance and Commitment Therapy; S/R = spirituality and/or religion.

Table 3 summarizes descriptive statistics on ACT psychotherapists' attitudes pertaining to mental health practice. Almost all ACT respondents felt that S/R issues were relevant to mental health at least some of the time (96%) and about a quarter of the respondents (26%) thought they were "often" or "always" relevant. By comparison, 42% of the CBT practitioners in the Delaney et al. (2013) study thought that S/R issues were often or always relevant. In terms of personal practice, a majority of the current sample reported that S/R issues were at least sometimes relevant in the therapy they provided (84%), that they often inquired about client S/R beliefs (57%), that clients brought up S/R issues at least sometimes (74%), and that they felt comfortable (79%) and competent (67%) discussing these issues with clients. Respondents seemed to feel more comfortable than competent in this regard. They also appeared more comfortable in comparison to CBT practitioners (64%), with twice as many ACT respondents reporting that they felt very comfortable (37%) as their CBT counterparts (19%).

Table 3

S/R Attitude Responses (and Percentages) of ACT Psychotherapists Pertaining to Mental Health

Item	Never	Rarely	Sometimes	Often	Always
How often are S/R issues relevant to MH?	1 (1.0)	3 (3.1)	68 (70.1)	23 (23.7)	2 (2.1)
How often are S/R issues relevant in the therapy you provide?	2 (2.1)	14 (14.4)	67 (69.1)	12 (12.4)	2 (2.1)
How often do you inquire about or asses your clients' S/R beliefs?	3 (3.1)	9 (9.3)	30 (30.9)	34 (35.1)	21 (21.6)
How often do your clients bring up S/R issues?	2 (2.1)	23 (23.7)	66 (68.0)	6 (6.2)	0 (0.0)
Item	**Not at all**	**Slightly**	**Somewhat**	**Mostly**	**Very Much**
How comfortable are you in addressing S/R issues in treatment?	1 (1.0)	8 (8.2)	11 (11.3)	41 (42.3)	36 (37.1)
How competent are you in discussing S/R issues with clients?	2 (2.1)	8 (8.2)	22 (22.7)	48 (49.5)	17 (17.5)

Note. Percentages are rounded to the nearest tenth. ACT = Acceptance and Commitment Therapy; S/R = spirituality and/or religion; MH = mental health.

Relationship among Personal S/R, Demographic Variables, and Mental Health Attitudes

Spearman's rank-order correlations were used to examine the relationship among ACT S/R characteristics, demographic variables and mental health attitudes (see Table 4). Weak to moderate positive correlations were found between most S/R variables, demographic and mental health attitudes. As might be expected, age and experience brought a higher degree of comfort and felt competence in addressing and discussing S/R issues ($p < .001$), and were also positively related to S/R relevance to mental health and personal therapeutic practice ($p < .001$).

Table 4

Spearman's Rho Correlations (and Significance) between Personal S/R and MH Variables

Personal S/R	MH1	MH2	MH3	MH4	MH5	MH6
Age	0.340**	0.460**	0.031	0.059	0.369**	0.435**
	(0.001)	(<0.001)	(0.760)	(0.565)	(<0.001)	(<0.001)
Experience	0.350**	0.396**	0.101	0.187	0.368**	0.374**
	(<0.001)	(<0.001)	(0.326)	(0.066)	(<0.001)	(<0.001)
Religious Attendance	0.254*	0.192	0.122	0.302**	0.247*	0.247*
	(0.012)	(0.060)	(0.233)	(0.003)	(0.015)	(0.015)
Private S/R Rituals	0.344**	0.410**	0.091	0.179	0.216*	0.243*
	(0.001)	(<0.001)	(0.375)	(0.079)	(0.034)	(0.016)
Importance of Religion	0.284**	0.250*	0.006	0.232*	0.191	0.295**
	(0.005)	(0.014)	(0.956)	(0.022)	(0.061)	(0.003)
Importance of Spirituality	0.412**	0.450**	0.036	0.314**	0.314**	0.320**
	(<0.001)	(<0.001)	(0.726)	(0.002)	(0.002)	(0.001)
Effectiveness in living out beliefs	0.146	0.210*	0.185	0.256*	0.402**	0.413**
	(0.154)	(0.039)	(0.069)	(0.011)	(<0.001)	(<0.001)

Note. S/R = spirituality and/or religion; MH = mental health; MH1 = relevance of S/R to MH; MH2 = relevance of S/R to own practice; MH3 = inquiring about client S/R; MH4 = clients bringing up S/R; MH5 = comfort with addressing S/R; MH6 = competence with discussing S/R.

* $p < .05$, two-tailed. ** $p < .01$, two-tailed.

Among S/R characteristics and mental health attitudes, the strongest relationships were found between mental health attitudes and effectiveness in living true to one's belief system and the importance of spirituality and mental health attitudes. In particular, moderately high correlations were found between rating spirituality as important and seeing it as relevant to mental health and personal therapeutic practice (< .001), and respondents who felt more comfortable and confident in addressing S/R issues were also those who tended to live more true to their belief systems (< .001). A moderately strong relationship was also found between the practice of religious rituals and a belief that S/R issues were relevant to personal therapeutic practice.

Some significant, albeit weaker relationships, were also found among other variables. The weakest correlations existed with the item asking respondents to rate how often they brought up S/R issues in their clinical practice, and none were significant. Because of the weakness of this item, it is excluded from further analyses.

The Use of ACT Processes

The next set of analyses examined self-assessed competence with ACT and the use of core ACT processes overall, as well as the relationship between using ACT processes, demographic and S/R characteristics and attitudes. Table 5 breaks down self-assessed competence with ACT and the use of core ACT processes. Three quarters of the sample rated themselves as being either "mostly" or "very much," competent with ACT while another 20% rated themselves as somewhat competent. Values/Commitment interventions were the most popular among the respondents with 99% of the sample reporting that they used these strategies at least "somewhat" and over three quarters of the respondents indicating that they did so "very

much." The next most frequently used ACT interventions aligned with Acceptance/Defusion work with 92% indicating either "mostly" or "very much," followed by Present Moment/Self-as-Context process, which had the highest percentage of respondents reporting "somewhat" or lower (17%), but still with over 84% of the sample stating that they employed interventions in this area.

Table 5

Responses (and Percentages) of Items Measuring Use of ACT

Item	Not at all	Slightly	Somewhat	Mostly	Very Much
How competent are you with ACT?	0 (0.0)	2 (2.1)	20 (20.6)	46 (47.4)	29 (29.9)
In your clinical work, how much do you value, in the sense of utilizing, each of these processes?					
Acceptance/Defusion	0 (0.0)	2 (2.1)	6 (6.2)	21 (21.6)	68 (70.1)
Present Moment/Self-as-Context	0 (0.0)	4 (4.1)	12 (12.4)	32 (33.0)	49 (50.5)
Values/Commitment	0 (0.0)	0 (0.0)	1 (1.0)	19 (19.6)	77 (79.4)

Note. Percentages are rounded to the nearest tenth. ACT = Acceptance and Commitment Therapy.

To further analyze the difference between the three ACT process clusters, the Friedman test, a nonparametric within-subjects alternative to a one-way Analysis of Variance (ANOVA), was used to compare the total ranks in each process cluster for significant levels of variance. The results of this analysis revealed a significant difference between the ACT processes, X_R^2 (2) = 40.177, $p <$ .001, with Values/Commitment having the highest mean rank, followed by Acceptance/Defusion, and Present Moment/Self-as-Context with the lowest mean rank (see Table 6). Analysis of smaller subsections of the current sample revealed the same significant differences and rankings, with a few exceptions. Specifically, no significant differences in ACT process clusters were found for

respondents who reported a high frequency of performing private S/R rituals (n = 34), X_R^2 (2) = 3.500, p > .05, or for those respondents who rated spirituality as "very much" important (n = 43), X_R^2 (2) = 3.937, p > .05. Additionally, there were no significant differences between ACT process clusters for respondents who identified as either Christian/Catholic (n = 21) or Agnostic (n = 20), X_R^2 (2) = 2.000, p > .05, X_R^2 (2) = 4.621, p > .05, respectively.

Table 6

Friedman Statistics for Comparing ACT Process Clusters

	Mean Ranks	*n*	Chi-Square	df	Sig
Whole sample					
Acceptance/Defusion	2.06	97	40.177	2	<.001
Present Moment/Self-as-Context	1.70				
Values/Commitment	2.25				
High frequency of Private Rituals (Often/Always)					
Acceptance/Defusion	2.00	34	3.500	2	.174
Present Moment/Self-as-Context	1.90				
Values/Commitment	2.10				
High spirituality (Very Much Important)					
Acceptance/Defusion	1.97	43	3.937	2	.140
Present Moment/Self-as-Context	1.93				
Values/Commitment	2.10				
Christian/Catholic					
Acceptance/Defusion	1.93	21	2.000	2	.368
Present Moment/Self-as-Context	2.12				
Values/Commitment	1.95				
Agnostic					
Acceptance/Defusion	2.05	20	4.621	2	.099
Present Moment/Self-as-Context	1.78				
Values/Commitment	2.18				

Note. ACT = Acceptance and Commitment Therapy; df = degrees of freedom; Sig = significance.

Table 7

Spearman's Rho Correlations (and Significance) between S/R and ACT Processes

S/R Variables	ACT Competence	Acceptance/ Defusion	Present Moment/ Self-as-Context	Values/ Commitment
Age in years	0.256*	0.231*	0.292**	0.073
	(0.011)	(0.023)	(0.004)	(0.477)
Experience in years	0.317**	0.310**	0.280**	0.165
	(0.002)	(0.002)	(0.005)	(0.107)
Religious Attendance	-0.012	0.083	0.168	0.052
	(0.906)	(0.416)	(0.099)	(0.611)
Private S/R Rituals	-0.07	0.16	0.267**	0.057
	(0.499)	(0.117)	(0.008)	(0.579)
Importance of Religion	0.004	0.024	0.067	-0.045
	(0.972)	(0.817)	(0.517)	(0.662)
Importance of Spirituality	0.069	0.083	0.338**	-0.052
	(0.503)	(0.421)	(0.001)	(0.614)
Effective in living out beliefs	0.348**	0.276**	0.321**	0.177
	(<0.001)	(0.006)	(0.001)	(0.082)
Relevance of S/R to MH	-0.012	0.000	0.125	-0.184
	(0.908)	(0.997)	(0.221)	(0.071)
Relevance of S/R to your practice	0.097	0.093	0.219*	0.063
	(0.346)	(0.365)	(0.031)	(0.542)
Inquiring about client S/R	0.163	0.042	0.132	0.239*
	(0.110)	(0.685)	(0.198)	(0.018)
Clients bringing up S/R	0.17	0.085	0.244*	0.154
	(0.096)	(0.410)	(0.016)	(0.131)
Comfort with addressing S/R	0.435**	0.142	0.246*	0.152
	(<0.001)	(0.165)	(0.015)	(0.136)
Competence with discussing S/R	0.351**	0.114	0.247*	0.203*
	(<0.001)	(0.266)	(0.015)	(0.046)

Note. S/R = spirituality and/or religion; ACT = Acceptance and Commitment Therapy.

* $p < .05$, two-tailed. ** $p < .01$, two-tailed.

Finally, relationships were explored between demographic and S/R characteristics, and the utilization of ACT processes using the Spearman's rank correlation coefficient (see Table 7). Most of these correlations were weak to low moderate ($p < .25$), but some interesting patterns emerged. Age and years of experience were positively and significantly correlated with the use of Acceptance/Defusion and Present Moment/Self-as-Context interventions, but not with Values/Commitment interventions. Competency as an ACT psychotherapist was also significantly correlated with living true to one's belief system ($p < .001$), and living true to one's belief system, as well as viewing spirituality as personally important, were more strongly related to using Present Moment/Self-as-Context interventions (< .001). Finally self-assessed ACT competence was more strongly related to one's comfort and competence in addressing S/R issues clinically.

Thus, overall, these data reflect that all ACT processes were frequently used by respondents and that the majority felt more than somewhat competent with ACT.

Discussion

An unexpected result of this study is that almost half of the respondents identified as atheist, agnostic, and/or having no religious affiliation. Although this supports previous research regarding a lower rate of religiosity among mental health professionals compared to the American public, ACT psychotherapists seem to have a high proportion of religiously unaffiliated clinicians when compared to other mental health professionals. Likewise, rated importance of religion and religious attendance were also much lower with the current sample. However, a majority of ACT psychotherapists appear to value spirituality at least as much, or more than, their CBT counterparts, and those who practice private S/R rituals at least sometimes

also constituted a majority. This suggests a strong sense of private, individualistic, and relative spirituality among ACT psychotherapists that is very separate from a more institutional, collective, and defined religious belief system.

ACT psychotherapists seem to have a larger proportion of Eastern/Buddhist clinicians and a smaller proportion of Judeo-Christian clinicians than other mental health professionals, including their CBT counterparts. This is not surprising, given the Eastern roots, language, and practices prevalent with ACT, which may seem attractive to some psychotherapists and religiously incongruent to others. Additionally, these results conflict somewhat with past research showing associations between Eastern beliefs and a humanistic orientation, as well as Christian beliefs and a cognitive-behavioral orientation (Bilgrave & Deluty, 1998, 2002). Indeed, when comparing third-wave CBT approaches to traditional CBT, third-wave psychotherapists may use more humanistic/existential techniques, perhaps given its focus on values and experiential acceptance, as well as systems theory strategies that are perhaps due to its use of contextual factors (Brown et al., 2011). Regardless of its Eastern roots, the broad clinical nature of ACT and its overlap with various orientations may feel somewhat fitting for psychotherapists of different S/R beliefs.

There may be, however, a more complex layer of understanding Buddhist or Eastern belief systems and private rituals. Some ACT psychotherapists may adopt Eastern belief systems in a more traditional, religious or spiritual sense, while others may see such belief systems as simply a secular, practical way of living (Batchelor, 2012). For example, it is unclear how participants who meditate regularly responded to the survey item inquiring about private S/R rituals, as their responses might depend on how spiritual they consider their meditative practices to be. In addition, there may be a bidirectional influence between a psychotherapist's personal

S/R and theoretical orientation. Rather than choosing to use ACT because of their Buddhist beliefs, for example, it is possible that psychotherapists were introduced to secular mindfulness exercises through these approaches and then chose to adopt Buddhist S/R and/or practices. Although not measured in the current study, a bidirectional pattern between therapist S/R and orientation was demonstrated by Bilgrave and Deluty (1998) who noted that 66% of psychologists in their sample felt that their clinical practice influenced their S/R and vice-versa. Thus, S/R beliefs could influence the clinical practice of some ACT psychotherapists as the use of ACT could influence their personal S/R.

As demonstrated with other mental health professionals, a large majority of ACT psychotherapists seem to find S/R at least sometimes relevant to mental health and to their own practices with clients. However, ACT therapists did not find S/R to be often or always relevant as much as CBT practitioners, possibly reflecting the relatively higher percentage of ACT psychotherapists who identified as either atheist, agnostic, or religiously unaffiliated. In addition, a majority of ACT respondents felt comfortable in addressing S/R, although a smaller percentage, albeit the majority, felt competent in discussing S/R issues in therapy. Interestingly, twice as many participants reported feeling very comfortable (37%) than those who felt very competent (18%) in discussing S/R with clients. One explanation could be a general willingness and comfort among mental health professionals concerning discussions around S/R, but with a lack of formal training, as this topic is not often discussed in training programs (Elkonin, Brown, & Naicker, 2014; Rosmarin, Pargament, & Robb, 2010; Rosmarin et al., 2013; Shafranske & Gorsuch, 1984). Additionally, when compared to CBT practitioners, ACT psychotherapists may feel more comfortable with discussing S/R issues despite a lack of training.

Like other mental health professionals, higher levels of personal S/R among ACT psychotherapists appear to be associated with increased feelings of relevance, comfort, and competence regarding S/R in mental health. In addition, higher levels of personal S/R appears to be linked with higher frequency of therapists' reports of clients bringing up these issues in therapy. This has similarly been demonstrated in past research, and has thought to be due to higher psychotherapist sensitivity to client S/R (Hofmann & Walach, 2011; Ragan et al., 1980). Interestingly, the frequency of ACT psychotherapists inquiring about client S/R was not affected by personal S/R, although ACT psychotherapists seem to inquire just as much, if not more than, APA psychologists and CBT practitioners. In addition, the frequency of inquiring about client S/R was correlated with ACT psychotherapists' use of Values and Commitment processes with clients. Indeed, ACT focuses on helping clients accept their experiences to live a more fulfilling life by determining their values, including those that pertain to S/R (Hayes, 2004). Thus, inquiring about patient S/R may become a practice driven more by theory and effectiveness rather than the S/R of ACT psychotherapists.

ACT psychotherapists' levels of spirituality, rather than religion, seemed to have the strongest and most consistent association with their clinical attitudes and practice in regards to S/R. One possible explanation would be a general trend among both mental health professionals and the public to turn away from organized religion (Shafranske & Cummings, 2012) and move towards a more private and malleable sense of spirituality. Moving from rigid, rule-governed behavior to more flexible, values-driven action is also reflected in the processes of ACT.

A vast majority of respondents reported regularly utilizing all of the ACT processes with clients, which is not surprising given the theoretically interdependent, non-hierarchical nature of these processes within ACT therapy (Hayes et al., 2013). However, there still appeared to be

some subtle differences between the ratings of process clusters. In terms of rank orders, Values/Commitment interventions appeared to be used most often, followed by Acceptance/Defusion, and Present Moment/Self-as-Context being used the least. This ranking remained true for most substantial subgroups of respondents of various demographics, personal S/R, and S/R attitudes in mental health, with a few exceptions.

While respondents favored Values/Commitment interventions, personal and professional confidence was not as strongly related to doing Values/Commitment work as they were with other ACT processes. This may be due to the fact that Values/Commitment represents a more basic, behavioral, and easily understood cluster of ACT processes that seem most directly related to setting goals and promoting change in clients' lives. Other ACT processes, however, may be more complex, allowing for age and experience to provide increasing competence and ability to execute them. Regarding the influence of S/R variables, only inquiring about client S/R and competence in discussing S/R issues were associated with higher use of Values/Commitment interventions. As mentioned earlier, this makes sense considering the process of assessing client values in therapy. The Values/Commitment processes may very well involve assessing and discussing client S/R in terms of how they are currently living out these beliefs and how their S/R effectively influences their goals and desired behaviors to make for a more meaningful life.

Out of all the ACT processes, the least utilized were Present Moment/Self-as-Context processes, which focus on undermining ineffective fixation on a rigid, conceptualized sense of self while expanding experience in the present moment and self-as-context (for elaboration, see Hayes et al., 2006). The lower frequency of using these processes with clients might be understandable given that the theoretical concepts and utility of mindfulness, sense of self, and RFT can be elusive, complex, and easily misunderstood by mental health professionals (Gardner,

Moore, & Marks, 2014; Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013; Westrup, 2014).

However, it seems that psychotherapists who tend to use Present Moment/Self-as-Context processes more also tended to have more significant interactions with personal and professional S/R factors. Specifically, they reported higher levels of private S/R rituals, spirituality, effectiveness in living out their belief system, relevance of S/R to their practices, frequency of clients bringing up S/R, and competence in discussing S/R with clients. Indeed, the aim of these processes, specifically learning to take different perspectives and being aware that you are noticing your own experience in a given moment, can be a somewhat spiritual experience (Hayes, 1984; Hayes et al., 2013). As Hayes et al. (2013) put it, "the limits of perspective taking cannot be consciously known (e.g., you cannot consciously note the limits of consciousness) and thus provide a transcendent, spiritual aspect to human experience. This idea was one of the seeds from which both ACT and RFT grew" (p. 186). Thus, psychotherapists who place stronger importance on spirituality and living out their beliefs, as well as noticing and addressing these issues with their clients, may find these processes easier to understand from experience and/or may feel more comfortable in working with others in this way. The mere familiarity and inclination in using private rituals, such as prayer or meditation, in their personal lives may also explain a more favorable tendency and comfort with using mindfulness interventions with clients.

Although Acceptance/Defusion interventions were the second most utilized process cluster, they had little interaction with S/R variables other than a significant correlation with effectively living out personal beliefs. This particular interaction may possibly be better explained by interactions with other general competence variables, such as age, years of

experience, and competence in ACT. Thus, it seems that ACT psychotherapists generally value and utilize Acceptance/Defusion techniques regardless of their personal S/R or professional attitudes regarding S/R.

There were no significant differences between religious affiliation responses for any S/R variables or ACT process items. However, when comparing the mean ranks of ACT processes, as mentioned earlier, both the Christian/Catholic and Agnostic groups were the only substantial sample subgroups that had no significant difference between their ACT process rankings. In other words, unlike most ACT psychotherapists who tend to use Values/Commitment interventions the most and Present Moment/Self-as-Context interventions the least, Christians and Agnostics may have tended to rate these processes more evenly. These results are interesting and somewhat unclear, as they might suggest less focus on Values/Commitment and/or more focus on Present Moment/Self-as-Context interventions, the reasons for which are unknown. The data may also be limited by a small sample size, which makes interpretation untenable.

Overall, the use of ACT processes seems somewhat affected by personal and professional S/R beliefs and attitudes. This is not surprising given the spiritual roots and language of ACT, especially regarding Present Moment/Self-as-Context processes, as well as the experiential nature of ACT therapy for both the client and the therapist. Additionally, personal S/R has been found to be influential on one's practice given a psychotherapist's values and how they live out these values in their work with clients (Peteet, 2014). On the other hand, a lack of interaction between ACT processes and specific belief systems or other S/R variables may also speak to the pragmatic philosophical underpinnings of ACT (Hayes et al., 2013).

The current study had several limitations which should be considered when interpreting the results and planning for future research. The sample size was fairly small, especially when compared to past studies, limiting the validity and reliability of the statistical analyses used. The sample also consisted of a high percentage of White respondents (91%) and may have possibly underrepresented ACT psychotherapists of ethnic minorities. In addition, there may have been a bias for respondents who chose to take the survey and perhaps had special interest in S/R, although this bias was not measured in the current study. Past studies that surveyed mental health professionals on S/R have demonstrated a noticeable bias from respondents, as these professionals perhaps place more value on S/R and thus notice it more in their work (Shafranske & Cummings, 2013).

Another possible limitation of the study that needs further research is the use of language when referring to one's S/R affiliation and rituals in order to discriminate between what is secular and what is sacred. Questioning respondents on their religious rituals, for instance, may unfairly group together those that practice spiritual meditation and those that practice secular meditation. A similar issue is whether a Buddhist affiliation refers to a spiritual, religious, and/or a secular understanding and practice of Buddhism. Further, those identifying as Atheist, Agnostic, and having no religious affiliation have often been grouped together in past studies, although these groups may differ greatly in their understanding or belief in S/R. Unfortunately, this study was not specific enough, nor was the sample size large enough, to explore the differences between these groups. However, it would be interesting to examine these differences among mental health professionals in future research.

Finding variability among ACT psychotherapists' use of different ACT processes proved difficult in the current study, perhaps due to the way these items were worded in the survey.

Indeed, most ACT psychotherapists probably strive to value and integrate all six ACT processes somewhat equally with their clients, thus reporting high use of each and making it difficult to find measurable differences. For future studies, it may be more helpful to have respondents rank their use of each ACT process, or specify their use by estimating a percentage of how much time they spend on or how relevant they find each process.

Finally, it should be noted that the correlations in the current study did not measure the direction of influence between a psychotherapist's personal S/R and their practice. Bilgrave and Deluty's (1998) findings concerning the bidirectionality of one's personal beliefs and one's practice, especially among those who identified with more Eastern or Mystical S/R, may have been an enlightening process to measure in the current study, and is certainly recommended for future research to help disentangle how psychotherapists with different S/R and theoretical orientations tend to relate to the two.

The results of this study provide a unique and initial look into the S/R beliefs and behaviors of psychotherapists that use ACT, a theoretical framework that is thought to be more relevant to and even originating from spirituality than other theoretical orientations. Overall, ACT psychotherapists seem to be much less religious in terms of affiliation and outward, institutional practices than the general public and other mental health professionals, yet place a high level of importance on spirituality and more personal forms of S/R practice. As expected, higher levels of S/R of ACT psychotherapists indicate more favorable attitudes and behaviors regarding S/R within mental health. This was found to be true even when ACT psychotherapists favor the use of particular ACT processes with clients. Specifically, psychotherapists who tend to use more Values/Commitment interventions may inquire about and discuss client S/R more often. Present Moment/Self-as-Context interventions, however, were utilized more by

psychotherapists who were more spiritual in their personal lives and who felt more competent with and had more clients bring up S/R issues in their practice. The implications of these results suggest a possible bidirectional influence of a psychotherapist's S/R and their practice, an influence that is essential for psychotherapists to be aware of and intentional about when delivering multiculturally competent and effective treatment to their spiritually diverse clientele.

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